Pediatric Health Questionnaire

Account # _____

Patient Name_____ Today's Date: _____

Referred by_____ Date of Birth: ____/____/____ Age: _____ Gender: M / F

Street Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian 1: _____

Preferred Phone # (_____) _____-_____ E-Mail address: _____

Parent/Guardian 2: _____

Preferred Phone # (_____) _____-_____ E-Mail address: _____

Insurance Co_____ Policy Holder Name_____ Policy Holder DOB_____

Consent for Treatment of a Minor

I hereby authorize Dr. Tagliarini and whomever he/she may designate as assistants to administer examinations and Chiropractic care as deemed necessary to my child.

Parent or Guardian's Name (printed): _____

Parent or Guardian's Signature: _____

Please provide the names of any of your child's healthcare providers that we have permission to share medical records with:

Pediatrician _____ Midwife/OB _____

Lactation consultant _____ Other _____

Parent/Guardian 1 Signature: _____

Parent/Guardian 2 Signature: _____

1. Describe your child's current symptoms :

_____

_____

_____

2. How long? _____ 3. How frequent? _____

4. What treatments have you tried for current symptoms? _____

5. What makes symptoms better? _____

6. What makes it worse? _____

7. Goals of care?_____

7. Birth History: ***(check all that apply)***

- ☐ Born on time ?
- ☐ # of Days before due date?_____
- ☐ # of Days after due date? _____
- ☐ Went into labor naturally
- ☐ Medically induced labor
- ☐ Pitocin used
- ☐ Water broke naturally
- ☐ Water broken by doctor
- ☐ Vaginal birth - location:_____
- ☐ Scheduled cesarean
- ☐ Emergency cesarean
- ☐ Epidural used
- ☐ Forceps Used
- ☐ Vacuum extraction used
- ☐ Umbilical cord around neck
- ☐ How long did mom push?_____
- ☐ Other_____

8. Feeding History: ***(check all that apply)***

- ☐ Nursed? How long? _____
- ☐ Pumping currently
- ☐ Formula fed
- ☐ Tongue / lip tie (CIRCLE)
- ☐ Difficulty nursing / latching (CIRCLE)
- ☐ Lactation consultant utilized

9. Other History: ***(check all that apply)***

- ☐ Frequent ear infections
- ☐ Frequent Illness (cold/sick)
- ☐ Frequent fevers
- ☐ RSV
- ☐ Antibiotic Use
- ☐ Tonsillitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive gassiness
- ☐ Excessive spit up
- ☐ Colic
- ☐ Reflux
- ☐ Torticollis
- ☐ Overall body tension
- ☐ Motor / speech delays (CIRCLE)
- ☐ Frequent crying spells
- ☐ Sleeping problems
- ☐ Scoliosis
- ☐ Allergies / Asthma (CIRCLE)
- ☐ Headaches
- ☐ Growing pains
- ☐ Bedwetting
- ☐ ADD / ADHD
- ☐ Up to date on vaccines

***10*. Pediatrician:** _____ ***11*. Date of Last Medical Physical**_____

12. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: _____

13. List all prescription and over-the-counter medications, nutritional/herbal supplements your child is taking:

_____

_____

14. List all the times your child has been hospitalized & all surgeries:

_____

_____

15. ANY & ALL LIFETIME TRAUMA HISTORY to head, neck, or back (such as concussion, automobile accident, sports injury, etc.)...EVEN IF YOUR CHILD DID NOT HAVE ANY SYMPTOMS OR TREATMENT WITH THIS TRAUMA, STILL NOTE IT PLEASE.

_____

_____

Parent/Guardian Signature_____ ***Date***_____